

## § 146.180

(b) *Information described.* Subject to paragraph (d) of this section, information that must be provided under paragraph (a)(2) of this section is information concerning the following:

(1) Provisions of coverage relating to the following:

(i) The issuer's right to change premium rates and the factors that may affect changes in premium rates.

(ii) Renewability of coverage.

(iii) Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage.

(iv) Any affiliation periods applied by HMOs.

(v) The geographic areas served by HMOs.

(2) The benefits and premiums available under all health insurance coverage for which the employer is qualified, under applicable State law. See §146.150(b) through (f) for allowable limitations on product availability.

(c) *Form of information.* The information must be described in language that is understandable by the average small employer, with a level of detail that is sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied if the issuer provides each of the following with respect to each product offered:

(1) An outline of coverage. For purposes of this section, outline of coverage means a description of benefits in summary form.

(2) The rate or rating schedule that applies to the product (with and without the preexisting condition exclusion or affiliation period).

(3) The minimum employer contribution and group participation rules that apply to any particular type of coverage.

(4) In the case of a network plan, a map or listing of counties served.

(5) Any other information required by the State.

(d) *Exception.* An issuer is not required to disclose any information that

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is proprietary and trade secret information under applicable law.

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### Subpart F—Exclusion of Plans and Enforcement

#### § 146.180 Treatment of non-Federal governmental plans.

(a) *Requirements subject to exemption—*

(1) *Basic rule.* A sponsor of a non-Federal governmental plan may elect to exempt its plan, to the extent that the plan is not provided through health insurance coverage, (that is, it is self-funded), from any or all of the following requirements:

(i) Limitations on preexisting condition exclusion periods described in §146.111.

(ii) Special enrollment periods for individuals and dependents described in §146.117.

(iii) Prohibitions against discriminating against individual participants and beneficiaries based on health status described in §146.121, except that the sponsor of a self-funded non-Federal governmental plan cannot elect to exempt its plan from the requirements in §146.121(a)(1)(vi) and §146.122 that prohibit discrimination with respect to genetic information.

(iv) Standards relating to benefits for mothers and newborns described in §146.130.

(v) Parity in the application of certain limits to mental health benefits described in §146.136.

(vi) Required coverage for reconstructive surgery and certain other services following a mastectomy under section 2706 of the PHS Act.

(2) *Limitations.* (i) An election under this section cannot circumvent a requirement of this part to the extent the requirement applied to the plan before the effective date of the election.

(A) *Example 1.* A plan is subject to requirements of section 2706 of the PHS Act, under which a plan that covers medical and surgical benefits with respect to a mastectomy must cover reconstructive surgery and certain other services following a mastectomy. An

enrollee who has had a mastectomy receives reconstructive surgery on August 24. Claims with respect to the surgery are submitted to and processed by the plan in September. The group health plan commences a new plan year each September 1. Effective September 1, the plan sponsor elects to exempt its plan from section 2706 of the PHS Act. The plan cannot, on the basis of its exemption election, decline to pay for the claims incurred on August 24.

(B) *Example 2.* An individual is hired by a non-Federal governmental employer and reports to work on August 6. The individual has diabetes. Under the terms of the plan in effect on August 6, if an individual files an enrollment application within the first 30 days of employment, enrollment in the plan is effective as of the first day of employment. The individual timely files an enrollment application. The application is processed on September 10. The group health plan commences a new plan year each September 1. Effective September 1, the plan sponsor elects to exempt its plan from §146.121, which prohibits enrollment discrimination based on health status-related factors, by requiring new enrollees to pass medical underwriting. The plan cannot decline to enroll the individual effective August 6, even if he would not pass medical underwriting under the terms of the plan in effect on September 1.

(ii) If a group health plan is co-sponsored by two or more employers, then only plan enrollees of the non-Federal governmental employer(s) with a valid election under this section are affected by the election.

(3) *Stop-loss or excess risk coverage.* For purposes of this section, (i) Subject to paragraph (a)(3)(ii), the purchase of stop-loss or excess risk coverage by a self-funded non-Federal governmental plan does not prevent an election under this section.

(ii) Regardless of whether coverage offered by an issuer is designated as “stop-loss” coverage or “excess risk” coverage, if it is regulated as group health insurance under an applicable State law, then for purposes of this section, a non-Federal governmental plan that purchases the coverage is considered to be fully insured. In that event,

a plan may not be exempted under this section from the requirements of this part.

(4) *Construction.* Nothing in this part should be construed as imposing collective bargaining obligations on any party to the collective bargaining process.

(b) *Form and manner of election*—(1) *Election requirements.* The election must meet the following requirements:

(i) Be made in writing.

(ii) Be made in conformance with all of the plan sponsor’s rules, including any public hearing requirements.

(iii) Specify the beginning and ending dates of the period to which the election is to apply. This period can be either of the following periods:

(A) A single specified plan year, as defined in §144.103 of this subchapter.

(B) The “term of the agreement,” as specified in paragraph (b)(2) of this section, in the case of a plan governed by collective bargaining.

(iv) Specify the name of the plan and the name and address of the plan administrator, and include the name and telephone number of a person CMS may contact regarding the election.

(v) State that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through health insurance coverage.

(vi) Specify each requirement described in paragraph (a) of this section from which the plan sponsor elects to exempt the plan.

(vii) Certify that the person signing the election document, including (if applicable) a third party plan administrator, is legally authorized to do so by the plan sponsor.

(viii) Include, as an attachment, a copy of the notice described in paragraph (f) of this section.

(2) *“Term of the agreement” defined.* Except as provided in paragraphs (b)(2)(i) and (b)(2)(ii), for purposes of this section “term of the agreement” means all group health plan years governed by a single collective bargaining agreement.

(i) In the case of a group health plan for which the last plan year governed by a prior collective bargaining agreement expires during the bargaining process for a new agreement, the term

of the prior agreement includes all plan years governed by the agreement plus the period of time that precedes the latest of the following dates, as applicable, with respect to the new agreement:

(A) The date of an agreement between the governmental employer and union officials.

(B) The date of ratification of an agreement between the governmental employer and the union.

(C) The date impasse resolution, arbitration or other closure of the collective bargaining process is finalized when agreement is not reached.

(ii) In the case of a group health plan governed by a collective bargaining agreement for which closure is not reached before the last plan year under the immediately preceding agreement expires, the term of the new agreement includes all plan years governed by the agreement excluding the period that precedes the latest applicable date specified in paragraph (b)(2)(i) of this section.

(3) *Construction—(i) Dispute resolution.* Nothing in paragraph (b)(1)(ii) of this section should be construed to mean that CMS arbitrates disputes between plan sponsors, participants, beneficiaries, or their representatives regarding whether an election complies with all of a plan sponsor's rules.

(ii) *Future elections not preempted.* If a plan must comply with one or more requirements of this part for a given plan year or period of plan coverage, nothing in this section should be construed as preventing a plan sponsor from submitting an election in accordance with this section for a subsequent plan year or period of plan coverage.

(c) *Mailing address.* The plan sponsor should mail the election to: Centers for Medicare & Medicaid Services, Private Health Insurance Group, CMSO, 7500 Security Boulevard, S3-16-16, Baltimore, MD 21244-1850.

(d) *Filing a timely election—(1) Plan not governed by collective bargaining.* Subject to paragraph (d)(4) of this section, if a plan is not governed by a collective bargaining agreement, a plan sponsor or entity acting on behalf of a plan sponsor must file an election with CMS before the first day of the plan year.

(2) *Plan governed by a collective bargaining agreement.* Subject to paragraph (d)(4) of this section, if a plan is governed by a collective bargaining agreement, a plan sponsor or entity acting on behalf of a plan sponsor must file an election with CMS before the first day of the first plan year governed by a collective bargaining agreement, or by the 45th day after the latest applicable date specified in paragraph (b)(2)(i) of this section, if the 45th day falls on or after the first day of the plan year.

(3) *Verifying timely filing.* CMS uses the postmark on the envelope in which the election is submitted to determine that the election is timely filed as specified under paragraphs (d)(1) or (d)(2) of this section, as applicable. If the latest filing date falls on a Saturday, Sunday, or a State or Federal holiday, CMS accepts a postmark on the next business day.

(4) *Filing extension based on good cause.* CMS may extend the deadlines specified in paragraphs (d)(1) and (d)(2) of this section for good cause if the plan substantially complies with the requirements of paragraph (f) of this section.

(5) *Failure to file a timely election.* Absent an extension under paragraph (d)(4) of this section, a plan sponsor's failure to file a timely election under paragraph (d)(1) or (d)(2) of this section makes the plan subject to all requirements of this part for the entire plan year to which the election would have applied, or, in the case of a plan governed by a collective bargaining agreement, for any plan years under the agreement for which the election is not timely filed.

(e) *Additional information required—(1) Written notification.* If an election is timely filed, but CMS determines that the election document (or the notice to plan enrollees) does not meet all of the requirements of this section, CMS may notify the plan sponsor, or other entity that filed the election, that it must submit any additional information that CMS has determined is necessary to meet those requirements. The additional information must be filed with CMS by the later of the following dates:

(i) The last day of the plan year.

(ii) The 45th day after the date of CMS's written notification requesting additional information.

(2) *Timely response.* CMS uses the postmark on the envelope in which the additional information is submitted to determine that the information is timely filed as specified under paragraph (e)(1) of this section. If the latest filing date falls on a Saturday, Sunday, or a State or Federal holiday, CMS accepts a postmark on the next business day.

(3) *Failure to respond timely.* CMS may invalidate an election if the plan sponsor, or other entity that filed the election, fails to timely submit the additional information as specified under paragraph (e)(1) of this section.

(f) *Notice to enrollees*—(1) *Mandatory notification.* (i) A plan that makes the election described in this section must notify each affected enrollee of the election, and explain the consequences of the election. For purposes of this paragraph (f), if the dependent(s) of a participant reside(s) with the participant, a plan need only provide notice to the participant.

(ii) The notice must be in writing and, except as provided in paragraph (f)(2) of this section with regard to initial notices, must be provided to each enrollee at the time of enrollment under the plan, and on an annual basis no later than the last day of each plan year (as defined in §144.103 of this subchapter) for which there is an election.

(iii) A plan may meet the notification requirements of this paragraph (f) by prominently printing the notice in a summary plan description, or equivalent description, that it provides to each enrollee at the time of enrollment, and annually. Also, when a plan provides a notice to an enrollee at the time of enrollment, that notice may serve as the initial annual notice for that enrollee.

(2) *Initial notices.* (i) If a plan is not governed by a collective bargaining agreement, with regard to the initial plan year to which an election under this section applies, the plan must provide the initial annual notice of the election to all enrollees before the first day of that plan year, and notice at the time of enrollment to all individuals who enroll during that plan year.

(ii) In the case of a collectively bargained plan (including a self-funded non-Federal governmental plan that has been exempted from requirements of this part under §146.125(a)(2)), with regard to the initial plan year to which an election under this section applies, the plan must provide the initial annual notice of the election to all enrollees before the first day of the plan year, or within 30 days after the latest applicable date specified in paragraph (b)(2)(i) of this section if the 30th day falls on or after the first day of the plan year. Also, the plan must provide a notice at the time of enrollment to individuals who—

(A) Enroll on or after the first day of the plan year, when closure of the collective bargaining process is reached before the plan year begins; or

(B) Enroll on or after the latest applicable date specified in paragraph (b)(2)(i) of this section if that date falls on or after the first day of the plan year.

(3) *Notice content.* The notice must include at least the following information:

(i) The specific requirements described in paragraph (a)(1) of this section from which the plan sponsor is electing to exempt the plan, and a statement that, in general, Federal law imposes these requirements upon group health plans.

(ii) A statement that Federal law gives the plan sponsor of a self-funded non-Federal governmental plan the right to exempt the plan in whole, or in part, from the listed requirements, and that the plan sponsor has elected to do so.

(iii) A statement identifying which parts of the plan are subject to the election.

(iv) A statement identifying which of the listed requirements, if any, apply under the terms of the plan, or as required by State law, without regard to an exemption under this section.

(v) A statement informing plan enrollees that the plan provides for certification and disclosure of creditable coverage for covered employees and their dependents who lose coverage under the plan.

(g) *Subsequent elections*—(1) *Election renewal.* A plan sponsor may renew an

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election under this section through subsequent elections. The timeliness standards described in paragraph (d) apply to election renewals under this paragraph (g).

(2) *Form and manner of renewal.* Except for the requirement to forward to CMS a copy of the notice to enrollees under paragraph (b)(1)(viii) of this section, the plan sponsor must comply with the election requirements of paragraph (b)(1) of this section. In lieu of providing a copy of the notice under (b)(1)(viii), the plan sponsor may include a statement that the notice has been, or will be, provided to enrollees as specified under paragraph (f) of this section.

(3) *Election renewal includes provisions from which plan not previously exempted.* If an election renewal includes a requirement described in paragraph (a) of this section from which the plan sponsor did not elect to exempt the plan for the preceding plan year, the advance notification requirements of paragraph (f)(2) of this section apply with respect to the additional requirement(s) of paragraph (a) from which the plan sponsor is electing to exempt the plan.

(4) *Special rules regarding renewal of an election under a collective bargaining agreement.* (i) If protracted negotiations with respect to a new agreement result in an extension of the term of the prior agreement (as provided under paragraph (b)(2)(i)) under which an election under this section was in effect, the plan must comply with the enrollee notification requirements of paragraph (f)(1), and, following closure of the collective bargaining process, must file an election renewal with CMS as provided under paragraph (d)(2) of this section.

(ii) If a single plan applies to more than one bargaining unit, and the plan is governed by collective bargaining agreements of varying lengths, paragraph (d)(2) of this section, with respect to an election renewal, applies to the plan as governed by the agreement that results in the earliest filing date.

(h) *Requirements not subject to exemption.*

(1) *Certification and disclosure of creditable coverage.* Without regard to an election under this section, a non-Federal governmental plan must provide for certification and disclosure of cred-

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itable coverage under the plan with respect to participants and their dependents as specified under §146.115 of this part.

(2) *Genetic information.* Without regard to an election under this section that exempts a non-Federal governmental plan from any or all of the provisions of §146.111 and §146.121 of this part, the exemption election must not be construed to exempt the plan from any provisions of this part 146 that pertain to genetic information.

(3) *Enforcement.* CMS enforces these requirements as provided under paragraph (k) of this section.

(4) *Examples.*

(i)

*Example 1.* (A) Individual A is hired by a county that has elected to exempt its self-funded group health plan from certain requirements of paragraph (a)(1) of this section, including prohibitions against enrollment discrimination based on health status-related factors. Individual A applies for enrollment in the county's group health plan. Applicants must pass medical underwriting before being allowed to enroll in the plan. The plan requires an applicant to complete a medical history form and to authorize the plan to contact physicians regarding any medical treatments the applicant has received in the past 5 years. Individual A has Type 2 diabetes. He submits the required form, which reflects that condition. The plan also receives information from Individual A's physicians. While the plan's request to Individual A's physicians did not include a request for genetic information, the plan received information from a physician in response to its request for health information about Individual A, that one of Individual A's parents has Huntington's Disease. The Plan denies enrollment to Individual A.

(B) Individual A files a complaint with CMS that he has been denied enrollment in the plan because of genetic information the plan received. CMS investigates the complaint and determines that the plan uniformly denies enrollment to anyone who has Type II diabetes. CMS resolves the complaint in favor of the plan on the basis that the plan permissibly denied enrollment to Individual A under its exemption election because of the existence of a medical condition that uniformly disqualifies individuals from participating in the plan.

(ii)

*Example 2.* (A) Same facts as in *Example 1*, except Individual A does not have diabetes or any other preexisting medical condition; that is, there is no manifestation of a disease

or disorder with respect to Individual A at the time of his application for enrollment in the county's group health plan.

(B) In these circumstances, CMS resolves the complaint in favor of Individual A because CMS determines that the plan impermissibly denied enrollment to Individual A on the basis of genetic information. CMS instructs the plan to permit Individual A to enroll in the plan retroactive to the earliest date coverage would be effective under the terms of the plan based on the date of Individual A's enrollment application or hire, as applicable. CMS may impose a civil money penalty, as determined under subpart C of part 150.

(i) *Effect of failure to comply with certification and notification requirements—*

(1) *Substantial failure.* (i) *General rule.* Except as provided in paragraph (i)(1)(iii) of this section, a substantial failure to comply with paragraphs (f) or (h)(1) of this section results in the invalidation of an election under this section with respect to all plan enrollees for the entire plan year. That is, the plan is subject to all requirements of this part for the entire plan year to which the election otherwise would have applied.

(ii) *Determination of substantial failure.* CMS determines whether a plan has substantially failed to comply with a requirement of paragraph (f) or paragraph (h)(1) of this section based on all relevant facts and circumstances, including previous record of compliance, gravity of the violation and whether a plan corrects the failure, as warranted, within 30 days of learning of the violation. However, in general, a plan's failure to provide a notice of the fact and consequences of an election under this section to an individual at the time of enrollment, or on an annual basis before a given plan year expires, constitutes a substantial failure.

(iii) *Exceptions—*(A) *Multiple employers.* If the plan is sponsored by multiple employers, and only certain employers substantially fail to comply with the requirements of paragraphs (f) or (h)(1) of this section, then the election is invalidated with respect to those employers only, and not with respect to other employers that complied with those requirements, unless the plan chooses to cancel its election entirely.

(B) *Limited failure to provide notice.* If a substantial failure to notify enrollees of the fact and consequences of an elec-

tion is limited to certain individuals, the election under this section is valid only if, for the plan year with respect to which the failure has occurred, the plan agrees not to apply the election with respect to the individuals who were not notified and so informs those individuals in writing.

(2) *Examples.* (i) *Example 1:* A self-funded non-Federal group health plan is co-sponsored by 10 school districts. Nine of the school districts have fully complied with the requirements of paragraph (f) of this section, including providing notice to new employees at the time of their enrollment in the plan, regarding the group health plan's exemption under this section from requirements of this part. One school district, which hired 10 new teachers during the summer for the upcoming school year, neglected to notify three of the new hires about the group health plan's exemption election at the time they enrolled in the plan. The school district has substantially failed to comply with a requirement of paragraph (f) with respect to these individuals.

The school district learned of the oversight six weeks into the school year, and promptly (within 30 days of learning of the oversight) provided notice to the three teachers regarding the plan's exemption under this section and that the exemption does not apply to them, or their dependents, during the plan year of their enrollment because of the plan's failure to timely notify them of its exemption. The plan complies with the requirements of this part for these individuals for the plan year of their enrollment. CMS would not require the plan to come into compliance with the requirements of this part for other enrollees.

(ii) *Example 2:* Same facts as in Example 1, except the noncompliant school district failed to notify any enrollees regarding an election under this section. That is, the school district failed to provide the annual notice to current plan enrollees as well as the notice at the time of enrollment to new enrollees. The school district has substantially failed to comply with the requirements of paragraph (f) of this section. At a minimum, the election is invalidated with respect to all enrollees

of the noncompliant school district for the plan year for which the substantial failure has occurred. In this example, the plan decides not to cancel its election entirely. The election with regard to the other nine school districts remains in effect.

(iii) *Example 3.* Two non-Federal governmental employers cosponsor a self-funded group health plan. One employer substantially fails to comply with the requirements of paragraph (f) of this section. While the plan may limit the invalidation of the election to enrollees of the plan sponsor that is responsible for the substantial failure, the plan sponsors determine that administering the plan in that manner would be too burdensome. Accordingly, in this example, the plan sponsors choose to cancel the election entirely. Both plan sponsors come into compliance with the requirements of this part with respect to all enrollees for the plan year for which the substantial failure has occurred.

(iv) *Example 4:* A non-Federal governmental employer has elected to exempt its collectively bargained self-funded plan from certain requirements of this part. The collective bargaining agreement applies to five plan years, 2001 through 2005. For the first three plan years, enrollees are notified annually and at the time of enrollment of the election under this section. The notice specifies that the election applies to the period January 1, 2001 through December 31, 2005. Prior to the dissemination of the annual notice for the 2004 plan year, the individual responsible for disseminating the notice terminates employment. His replacement, who is unaware of the requirement that plan enrollees be notified annually, continues to notify new enrollees at the time of enrollment but fails to disseminate the annual notice. CMS does not consider that failure to be a substantial failure because enrollees previously had actual notice that the election under this section applies for the period January 1, 2001 through December 31, 2005. Accordingly, CMS would not invalidate the election for the 2004 plan year.

(v) *Example 5:* A non-Federal governmental employer has elected to exempt its self-funded plan from certain re-

quirements of this part. An individual terminates employment with the governmental employer, which fails to automatically provide a certificate of creditable coverage within the period specified in § 146.115(a)(2)(ii)(A). (The governmental employer generally provides certificates to terminated employees on an automatic basis, but neglected to do so in this case.) The oversight is brought to the employer's attention when the individual inquires as to why he has not received his certificate of creditable coverage. The governmental employer promptly (within 30 days) forwards a certificate to the individual. CMS would not view that situation as constituting a substantial failure and would not invalidate the election under this section.

(j) *Election invalidated.* If CMS finds cause to invalidate an election under this section, the following rules apply:

(1) CMS notifies the plan sponsor (and the plan administrator if other than the plan sponsor and the administrator's address is known to CMS) in writing that CMS has made a preliminary determination that an election is invalid, and states the basis for that determination.

(2) CMS's notice informs the plan sponsor that it has 45 days after the date of CMS's notice to explain in writing why it believes its election is valid. The plan sponsor should provide applicable statutory and regulatory citations to support its position.

(3) CMS verifies that the plan sponsor's response is timely filed as provided under paragraph (d)(3) of this section. CMS will not consider a response that is not timely filed.

(4) If CMS's preliminary determination that an election is invalid remains unchanged after CMS considers the plan sponsor's timely response (or in the event that the plan sponsor fails to respond timely), CMS provides written notice to the plan sponsor (and the plan administrator if other than the plan sponsor and the administrator's address is known to CMS) of CMS's final determination that the election is invalid. Also, CMS informs the plan sponsor that, within 45 days of the date of the notice of final determination, the plan, subject to paragraph (i)(1)(iii) of this section, must comply with all

requirements of this part for the specified period for which CMS has determined the election to be invalid.

(k) *Enforcement.* To the extent that an election under this section has not been filed or a non-Federal governmental plan otherwise is subject to one or more requirements of this part, CMS enforces those requirements under part 150 of this subchapter. This may include imposing a civil money penalty against the plan or plan sponsor, as determined under subpart C of part 150.

(l) *Construction.* Nothing in this section should be construed to prevent a State from taking the following actions:

(1) Establishing, and enforcing compliance with, the requirements of State law (as defined in §146.143(d)(1)), including requirements that parallel provisions of title XXVII of the PHS Act, that apply to non-Federal governmental plans or sponsors.

(2) Prohibiting a sponsor of a non-Federal governmental plan within the State from making an election under this section.

[67 FR 48811, July 26, 2002, as amended at 74 FR 51693, Oct. 7, 2009]

## PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

Sec.

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**AUTHORITY:** Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 USC 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

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### § 147.100 Basis and scope.

Part 147 of this subchapter implements the requirements of the Patient Protection and Affordable Care Act that apply to group health plans and health insurance issuers in the Group and Individual markets.

### § 147.108 Prohibition of preexisting condition exclusions.

(a) *No preexisting condition exclusions*—(1) *In general.* A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion (as defined in §144.103).

(2) *Examples.* The rules of this paragraph (a) are illustrated by the following examples (for additional examples illustrating the definition of a preexisting condition exclusion, see §146.111(a)(1)(ii)):

*Example 1.* (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer P. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer N. N's policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy.

*Example 2.* (i) *Facts.* Individual C applies for individual health insurance coverage with Issuer M. M denies C's application for coverage because a pre-enrollment physical revealed that C has type 2 diabetes.

(ii) *Conclusion.* In this *Example 2*, M's denial of C's application for coverage is a preexisting condition exclusion because a denial of an application for coverage based on the fact that a condition was present before the date of denial is an exclusion of benefits based on a preexisting condition.

(b) *Applicability*—(1) *General applicability date.* Except as provided in paragraph (b)(2) of this section, the rules of this section apply for plan years beginning on or after January 1, 2014; in the case of individual health insurance coverage, for policy years beginning, or